

**ENT REFERRAL FOR AUDIOLOGY SERVICES**

Date: .....

Patient Name: ..... Date of Birth: .....

Referring Doctor:..... Provider No.: .....

Address: ..... Telephone: .....  
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**Requested Diagnostic Audiology Items** (please tick or circle)

**Audiograms:**

- 82312** Air and Bone Conduction or Air Conduction and Speech Discrimination
- 82315** Air and Bone Conduction and Speech Discrimination
- 82318** Air and Bone Conduction and Speech Discrimination with other Cochlear

**Tympanograms:**

- 82324** Impedance only (used with VROA 10 months – 3 years old testing, not including items 82312, 82315, 82318)
- 82327** Impedance with Audiograms

**Other:**

- Auditory Processing Disorder Assessment
- Ear Plugs (Musician / Swimmers / Noise / Proplugs)
- Hearing instrument Fitting and Rehabilitation
- Tinnitus Assessment and Management
- .....

**Clinical Notes:**

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